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**Drug demand reduction: world situation with regard to drug abuse, in particular the spread of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) through drug injection**

## World situation with regard to drug abuse, in particular the spread of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) through drug injection

### Report of the Secretariat

## Contents


| | | Paragraphs | Page |
|---|---|---|---|
| I. | Introduction | 1-6 | 2 |
| II. | World drug situation with regard to emerging trends in drug abuse | 7-42 | 3 |
| | A. Heroin | 7-16 | 3 |
| | B. Amphetamine-type stimulants | 17-26 | 6 |
| | C. Cocaine | 27-33 | 8 |
| | D. Cannabis | 34-42 | 9 |
| III. | Drug injection and transmission of blood-borne viruses | 43-47 | 10 |
| IV. | Data collection: an information base for action | 48-49 | 12 |
| V. | Human immunodeficiency virus (HIV) infection among drug abusers: a key issue for the development of improved demand reduction responses | 50-53 | 12 |
| Annex. | Trends in drug abuse and country reporting | | 15 |


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# I. Introduction

1. In the Declaration of Commitment on human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) (General Assembly resolution S-26/2), adopted during the twenty-sixth special session of the General Assembly, held from 25 to 27 June 2001, heads of State and Government and representatives of States and Governments declared their commitment to address the HIV/AIDS crisis by, inter alia, ensuring that HIV/AIDS issues were included on the agenda of all appropriate United Nations conferences and meetings. At its intersessional meeting held on 16 November 2001, the Commission on Narcotic Drugs decided to include HIV/AIDS on its agenda in view of the significant impact of drug injection on the spread of HIV/AIDS and in compliance with the Declaration. Accordingly, the present report on the world drug situation with regard to drug abuse also covers the spread of HIV/AIDS through drug injection.

2. The present report is a review of patterns and trends in illicit drug consumption compiled for the year 2000. It includes a descriptive analysis of consumption patterns by drug type, consideration of the issue of drug-related viral infection and a discussion on developments in the global capacity to monitor illicit drug abuse. This issue is of particular importance in the period prior to the 2003 mid-term review of the progress that has been made towards meeting the targets agreed at the twenty-second special session of the General Assembly. An understanding of the extent and nature of the global drug problem is clearly a necessary prerequisite to that assessment process. The extent to which the data are available and the measures that have been taken to improve the global information base are discussed in section V. Special attention is also paid to drug injection and associated HIV infection, an issue that remains an important challenge for demand reduction efforts if the health and social costs of drug abuse are to be reduced significantly.

3. The present analysis is based on the responses from the 80 countries that had completed and returned part II of the annual reports questionnaire for the year 2000 by 13 December 2001, in compliance with their obligations under the international drug control treaties. The annual reports questionnaire was distributed to 193 countries in 2000 and the response rate was thus 41 per cent, a decline in relation to recent years: in 1999 117 countries submitted returns and in 1998 112. In some respects those figures are themselves misleading, as among returned questionnaires the number of non-responses (unanswered questions) was routinely high. Thus the actual data available for analysis were even less than the response rate suggests. For example, simple questions on trends in consumption of the major drug types—heroin, cocaine and cannabis—were answered by 45, 26, and 51 countries, respectively. This means that data were only available from between 13 and 27 per cent of all Member States for analysis. If the more quantitative questions are considered, for example, the section on prevalence estimates, then the situation is even worse. The response rate in this case is insufficient to permit meaningful analysis of the data.

4. Not all of the non-responses can be attributed to a lack of information in the reporting countries. Two additional factors also appear to be important. Firstly, the lack of information reflects shortcomings in the annual reports questionnaire (part II). This fact has been recognized by the Commission and part II of the questionnaire has been revised for the reporting cycle commencing in 2001. Secondly, there appears to be a problem of coordination, since some reports have not benefited from the technical information that is known to be available in Member States. For example, in many cases data are published by Governments—or by regional organizations on behalf of Governments—that do not appear in the annual reports questionnaire (part II) submission but are available elsewhere. Again this problem has been recognized by the Commission, which, in its resolution 44/3, called upon States to review the mechanism by which the data for part II of the annual reports questionnaire are currently being collated and submitted and to consider designating a technical focal point for assisting in the collation of data. It is hoped that the new format for part II and improvements in the coordination of the submission process will lead to a higher response rate, with both improvement in the numbers of countries making an annual submission and a reduction in the level of non-responses to individual questions.

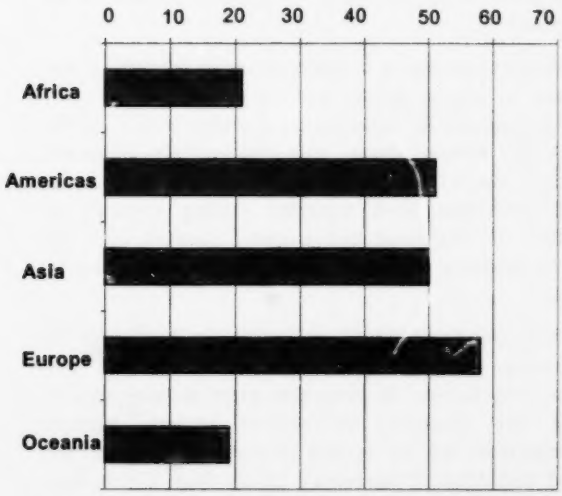
5. To improve the coverage of the present report, data from the annual reports questionnaire have been supplemented with information from other referenced sources, including the national reports that some

Member States attached to their submissions. The inclusion of this additional information reflects the practice adopted in previous years and is in line with the agreement of the Commission.[1]

Table
**Analysis of rates of response to the annual reports questionnaire (part II), by region**

| *Region* | *Number of annual reports questionnaires distributed* | *Number of annual reports questionnaires returned* | *Countries responding within each regional group (percentage)* |
|---|---|---|---|
| Africa | 53 (27%) | 11 (14%) | 21 |
| Americas | 35 (18%) | 18 (22%) | 51 |
| Asia | 44 (23%) | 22 (28%) | 50 |
| Europe | 45 (24%) | 26 (32%) | 58 |
| Oceania | 16 (8%) | 3 (4%) | 19 |
| **Total** | **193 (100%)** | **80 (100%)** | |

Figure
**Countries and territories responding, by region (percentage)**




6. One reason for supplementing data from the annual reports questionnaire with additional sources is to provide a more balanced regional perspective. A breakdown of responses by region can be found in the table and in the figure data are provided on the relative number of countries reporting in each regional group. Overall, no region is well represented. Even in Europe, where compliance with the reporting obligation was highest, nearly half of Member States did not make a submission. This simple analysis shows that African countries are particularly poorly represented and in general there was an observed bias towards developed countries in returns. Oceania was also under-represented as regards the ratio of questionnaires sent out to those received back; however, it should be noted that returns from this region were received from the larger countries in terms of size of population.

# II. World drug situation with regard to emerging trends in drug abuse

## A. Heroin

7. Heroin problems remain at the top of the illicit drug abuse agenda for many parts of the world and the abuse of this drug is responsible for considerable damage both to individuals and communities. Heroin is commonly smoked, injected and sometimes snorted (inhaled through the nose). Injecting heroin use is particularly damaging, especially when the behaviour exposes users to the risk of viral infection. Monitoring changes in the common mode of administration among heroin-abusing populations is therefore important. The issue of infection of drug abusers with HIV and other viruses is considered in detail below. In their responses to the annual reports questionnaire, 27 countries (60 per cent of those responding) reported that heroin abuse had increased during 2000. Nine countries (20 per cent of those responding) reported no change in abuse and a further nine (20 per cent) reported that abuse had decreased during the reporting period.

8. A simple overview of the global heroin situation would suggest that in Latin America and the Caribbean the drug is not widely consumed. In Africa, heroin use was also not perceived as a widespread problem; however, worrying reports of increased use were emerging from a number of large cities. This underlines the need for ongoing monitoring of the drug situation in Africa in order to detect the emergence of problematic trends in drug use. In North America problems were recorded, but heroin abuse was seen as largely stable, although particular concern existed about the possible increased use among young people who may be snorting/sniffing the drug. Heroin remains the primary problem drug in Europe. Trends were

reported as being broadly stable in the countries of the European Union (EU), but abuse was increasing in eastern Europe. In the Russian Federation and bordering countries, there were severe heroin abuse problems and concerns about increasing levels of drug injection. Heroin abuse was problematic in many of the countries of Central Asia and South-East Asia. However, in parts of South-East Asia, heroin abuse might be stable or even in decline, as methamphetamine was becoming the major drug of abuse for many countries in the region. Heroin abuse had fallen recently in Australia as a result of a shortage of supply. To some extent this had resulted in an increase in the use of cocaine, methamphetamine and other drugs.

9. Increasing heroin abuse was reported by all of the eastern European countries responding to the annual reports questionnaire. Specifically, large increases in heroin abuse were reported by Belarus, Greece, Hungary, Latvia, Lithuania, Poland and Romania, while some increase in abuse was reported by the Czech Republic and Estonia. Although most reports from western Europe indicated stable heroin use, namely those from Denmark, Ireland, Liechtenstein, the Netherlands and Switzerland, there were reports of increased heroin use from Finland, Sweden and Turkey. Portugal and Spain both reported some decrease in heroin abuse.

10. The most noteworthy trend in heroin use in Europe is the increase in use and associated problems in eastern European countries, with a level approaching that of western European countries, where the problem has since stabilized. Increasing heroin use in eastern Europe has replaced the traditional use of home-made opiates and there has been a corresponding increase in the number of injecting drug users (IDUs) and in drug-related mortality, which is thought to be due primarily to opioid overdose. Problems relating to heroin injection were particularly apparent in the Russian Federation, where the problem had increased notably since the mid-1990s.[2] There were also reports of heroin smoking among school students in eastern European countries. Based on the 1999 European School Survey Project on Alcohol and Other Drugs (ESPAD) survey conducted among students in 30 European countries, lifetime experience in heroin smoking was 3 per cent on average. However, it should be noted that that figure hid considerable national variation, with lifetime prevalence of heroin smoking being particularly high among students in Latvia and Romania (7-8 per cent) and Croatia, Italy, Lithuania, Poland and the Russian Federation (4-5 per cent). Injecting heroin use was far less commonly reported.[3]

11. The United States of America reported stable levels of heroin abuse, although recent evidence from the Community Epidemiology Work Group (CEWG) suggested that heroin abuse might be spreading to suburban and rural communities and among younger populations, with indicators for heroin abuse increasing in 15 of the cities within the country. Reports indicated that heroin was often being used in combination with cocaine, either concurrently or sequentially.[4] In the United States, the lifetime prevalence for heroin use among students in public and private secondary schools throughout the country remained steady at around 0.9-2.4 per cent in the 1990s, although the 2000 data showed an increase in the recent use of heroin among senior school students (12th graders) but a decline among younger students (8th graders).[5] Canada reported some increase in heroin abuse in the 2001 questionnaire, with lifetime heroin prevalence of 2.8 per cent among Ontario school students in 1999 and 1.9 per cent for use in the past year.[6]

12. Several countries in Latin America reported some increase in heroin abuse, namely, Colombia, Mexico and Panama, while Chile reported stable levels. In the Caribbean, heroin abuse was not widely reported, although use of the drug was not unknown. Some heroin problems were reported among subjects in treatment in Suriname and a small number (0.3 per cent) of students reported heroin use in the last month in Haiti.[7]

13. One trend noted was an increase in heroin use in developing regions where heroin abuse was not traditionally known. In particular, there were reports of heroin use emerging in several eastern African countries over the last decade (Kenya, Uganda and the United Republic of Tanzania), albeit from a very low baseline, and a continuing trend of heroin use among young adults in South Africa. There was also concern in some eastern African countries that local heroin trafficking would have an impact on levels of heroin abuse.[8] Several other African countries reported some increase in heroin use through the questionnaire, namely Cameroon, Namibia, South Africa and Zambia. Only two other countries in Africa reported on trends

in heroin consumption: Zimbabwe, where use was stable, and Nigeria, where there had been some decrease in the use of heroin. While injection of heroin is not the norm in African countries, there is growing evidence of pockets of heroin injection in urban centres (e.g. in Kenya, Nigeria and the United Republic of Tanzania).[9] Unlike most of its mainland counterparts, the island of Mauritius had an established population of opioid injectors, which evolved in the late 1980s to early 1990s, but abuse levels appeared to have remained stable for several years.

14. In South-East Asia, while heroin and other opioid use remain a significant problem, some evidence suggested a recent slight decline in the level of use. Decreased heroin use was reported by countries and territories in South-East Asia, namely, Hong Kong Special Administrative Region (SAR) of China, Indonesia, Japan, Malaysia, Myanmar and Singapore, while Brunei Darussalam reported stable heroin use. Reasons for the reported decrease in heroin abuse in South-East Asia vary. Myanmar, for instance, reported a rapid decline in heroin production following extensive law enforcement action, as well as changed patterns of use among heroin addicts, who had begun to use other drugs instead of heroin. Adverse weather conditions might also have played a role in declining opium production in the region.[10] There was also evidence from some countries within the region that use of heroin might have been replaced by use of methamphetamine. Some countries in the Asian region reported that heroin had been replaced by methamphetamine as the drug of choice among new initiates to drug abuse.

15. In Central Asia the heroin abuse situation remains highly problematic, although an absence of reliable data prevents an accurate assessment of trends. Furthermore, it is still too early to gauge the impact of the current situation in Afghanistan on heroin consumption patterns in the region. Given the number of individuals who are affected, the prevalence of drug injecting and the lack of resources for treatment and other services for drug abusers, the situation in Central Asia is of particular concern. Growing heroin problems were also reported in the Central Asian States of Kazakhstan, Kyrgyzstan, Tajikistan and Turkmenistan. Of particular concern is the growth in drug injecting. Again assessment is difficult as the data currently available remain poor, but the United Nations International Drug Control Programme (UNDCP) has been collaborating with Governments on a series of assessment studies in the region, which will be reported on in 2002. In India, the Islamic Republic of Iran and Pakistan, large opiate-abusing populations exist. Estimates vary considerably for the size of the total heroin abusing populations in those countries, with some figures suggesting extremely high male prevalence rates. A 1996 survey in India estimated that there were between 0.5 and 0.6 million drug-dependent individuals and that the drug-abusing population could be in the order of 3 million. A recent assessment exercise in Pakistan highlighted a serious heroin problem and estimated the number of chronic male addicts at around half a million individuals. That study also suggested that drug injection had now become a serious problem in the country, with around 15 per cent of heroin addicts regularly using that mode of administration. This contrasts with the situation in the mid-1990s where this mode of use was negligible. Good prevalence data are not available for Bangladesh, but rapid assessment studies carried out in 1996 suggested that the country had a significant heroin problem.

16. Australia has seen a recent decline in levels of heroin use, with concomitant reduction in heroin overdoses. This has been attributed to the heroin "drought" starting early in 2001,[11] which was marked by increased prices, decreased purity and decreased availability of heroin. While problems typically associated with heroin use, most notably heroin overdose, have declined following the heroin "drought", there has been a concomitant increase in the injection of other drugs (e.g. cocaine and amphetamine) and new problems associated with stimulant injection.[12, 13] An annual national survey of IDUs in Australia found that only 36 per cent reported heroin as the drug they injected most often in 2001 compared with 58 per cent in 2000.[14] The factors associated with the Australian heroin "drought" are currently being investigated and it will be interesting to see whether the reduction in opioid-related problems is sustained. The number of dependent heroin users in Australia was recently estimated at 74,000, or 6.9 per 1,000 inhabitants, in 1998—a steady but substantial increase in relation to the number of heroin users estimated in the mid-1980s (around 34,000 or 3.7 per 1,000 inhabitants).[15]

## B. Amphetamine-type stimulants

17. The term "amphetamine-type stimulants" (ATS) has been adopted to refer to synthetic central nervous system stimulant drugs such as amphetamine, methamphetamine and the chemically related Ecstasy group (methylenedioxymethamphetamine (MDMA) and its analogues). It should be noted that the chemical similarity of those substances is not reflected in similarly homogeneous abuse patterns. Patterns of use include chronic and dependent abuse by the socially marginalized, abuse by young, often socially well-integrated people in recreational settings and the instrumental use of stimulants by certain occupational groups or in particular work settings. The morbidity and mortality associated with ATS abuse is also influenced by the mode of administration employed. Among ATS there are drugs that can be injected, smoked, snorted/sniffed or consumed orally.

18. Seventeen (86 per cent) of the 20 countries reporting on trends in methamphetamine abuse noted an increase in levels of consumption. Amphetamine abuse, in contrast, was more stable, with only 11 countries (58 per cent of those responding) reporting an increase in abuse, with most of the remaining countries reporting stable use. The only countries to report decreasing amphetamine/methamphetamine abuse were the Czech Republic and Hungary. In addition to those countries reporting on amphetamine and methamphetamine abuse, nine countries and territories reported an increase in ATS abuse generally (Australia, Iceland, Indonesia, Lithuania, Macao SAR of China, Myanmar, New Zealand, Poland and Republic of Moldova) and a further six reported stable levels of abuse (Germany, Greece, Latvia, the Netherlands, Spain and United States). However, it must be noted that with respect to the reporting requirements on ATS, the Ecstasy group of drugs is inadequately covered in the distributed version of the annual reports questionnaire.

19. The increase in methamphetamine abuse was most commonly reported from countries in South-East Asia, where all States reporting noted an increase in levels of abuse (Brunei Darussalam, Hong Kong SAR, India, Japan, Malaysia, Philippines and Singapore). The latest annual reports questionnaire data available from Thailand also indicated an increase in methamphetamine abuse among youth in 1999, where it appeared to have replaced heroin as the primary problem drug. Statistics provided by the Central Registry of Drug Abuse in Hong Kong SAR show a 127 per cent increase for ATS from 1999 to 2000. Reports from the region also indicated that many consumers were using the crystalline form of methamphetamine, known locally as "shabu", because it can be easily smoked and gives a more intense drug effect. Smoking is an extremely efficient method of drug administration and is similar to drug injection with respect to the drug's speed of onset and bio-availability. Smoking methamphetamine is therefore likely to be associated with higher levels of dependence and other problems than other less efficient modes of administration. This is particularly worrying, as there appears to be a trend towards methamphetamine smoking in some countries. For example, in Thailand there has been a transition from swallowing (oral administration) to smoking methamphetamine over the last five years and, in 1999, the overwhelming majority of methamphetamine users were reported to be smoking the drug. Use of methamphetamine in Thailand is most widespread among students and young people, with occupational use also found among selected groups such as long-distance truck drivers.

20. An increase in ATS abuse was also reported in Australia and New Zealand. The Australian Illicit Drug Reporting System noted a continuing increase in the use of more pure forms of methamphetamine, including "ice" and "base" methamphetamine, in 2001. There is also evidence that in some regions of Australia, the recent heroin "drought" has also been associated with an increase in injection of methamphetamine.[12]

21. The Czech Republic and Hungary reported decreases in amphetamine and methamphetamine abuse, while reports from the remaining European countries suggested that levels of abuse were stable to increasing. It should be noted that most amphetamine in Europe is in the form of amphetamine sulphate. Methamphetamine problems have been restricted largely to the Czech Republic. Worryingly, some evidence is beginning to emerge that meth-amphetamine may be beginning to be available sporadically in some EU countries. Given the particularly high abuse potential of this drug and its association with high levels of problematic behaviour, this is of considerable concern. There is therefore a strong argument for the need to monitor any potential

diffusion of the drug in Europe to allow the development of early interventions should they become necessary.

22. In the 1990s ATS abuse increased in many eastern European cities. With respect to the use of Ecstasy, there were clear upward trends in both western and eastern European cities.[2] However, the most recent data from the EU region show that lifetime experience of amphetamine among the general population is still well below 5 per cent in most countries. Of the EU countries, the United Kingdom of Great Britain and Northern Ireland (data from England and Wales) reported a notably high rate, with 10 per cent lifetime use of amphetamine among the general population.[16] According to the ESPAD youth survey, the level of ATS use (especially with respect to amphetamine) among European adolescents was, in general, at a much lower level than was the case with their peers in the United States. In Europe the average of lifetime experience for both amphetamine and Ecstasy use was 2 per cent among young people of 15-16 years of age.[3] The trend in ATS use in EU is somewhat mixed and requires careful monitoring, but overall the situation appears to be stabilizing.

23. Several countries in the Americas reported an increase in methamphetamine abuse: Argentina, Canada, Colombia, Mexico and Peru. The situation with amphetamine appeared more stable in the Americas, with only Chile and Colombia reporting some increase and Argentina, Canada and El Salvador reporting stable levels of abuse. In the United States, there was evidence of increased use of methamphetamine during late 1999 to early 2000, in those areas which typically reported high levels of methamphetamine abuse, despite a downward trend prior to 1999. Methamphetamine remained concentrated in the western states of the country and some rural areas elsewhere. Significant increases in emergency department mentions were found recently in six of the CEWG monitoring sites (Atlanta, Denver, Phoenix, St. Louis, San Diego and Seattle). Methamphetamine remains the most common drug reported among treatment admissions in Honolulu and San Diego. Use of methamphetamine and crystal methamphetamine ("ice") have declined slightly among school students in the United States. Lifetime prevalence of methamphetamine use fell from 4.5-8.2 per cent (8th, 10th and 12th graders) in 1999 to 4.2-7.9 per cent in 2000. Similar trends were seen for the lifetime prevalence of "ice" among senior school students, with a drop from 4.8 per cent in 1999 to 4.0 per cent in 2000. In the United States, the lifetime prevalence for amphetamine use among adolescents in the 8th, 10th and 12th grades increased through the 1990s. Prevalence reached a peak in the lower two grades by 1996 (13.5 per cent in the 8th and 17.7 per cent in the 10th grade) and in the 12th grade by 1997 (16.5 per cent). The lifetime prevalence data from 2000 suggested a slight declining trend in amphetamine use across all grade levels, though still at 9.9 per cent in the 8th grade, 15.7 per cent in the 10th grade and 15.6 per cent in the 12th grade.[5]

24. Concern about the abuse of Ecstasy-type drugs is pronounced at present in the United States. That concern was reflected in the available data, which showed that more young Americans used Ecstasy than cocaine. Ecstasy use increased among all the age cohorts in the most recent Monitoring the Future study. Among 8th graders, last year prevalence rose from 1.7 per cent to 3.1 per cent between 1999 and 2000. For 10th graders the increase was from 4.4 per cent to 5.4 per cent for the same time period and for 12th graders last year use increased from 5.6 per cent to 8.2 per cent.[5] The CEWG surveillance network reported that Ecstasy abuse had become more widespread, with recent increases being reported in 13 areas across the United States. Ecstasy was being used in a variety of settings, including raves, house parties and singles bars, and some evidence existed to suggest that the age groups involved were getting younger. There had also been an increase in the number of emergency room patients reporting MDMA abuse, from 250 cases in 1994 to 2,850 cases in 1999.[4] Ecstasy abuse was also a concern in Canada. Recent data from Ontario showed that Ecstasy use was most common among young men, while men were three times more likely than women to have used the drug. Most users were aged between 18 and 29 years.[6]

25. Although cannabis and cocaine remained the predominant drugs taken in the Caribbean, there were concerns about the availability of ATS drugs and increased availability of Ecstasy in particular. Ecstasy use has been reported in Aruba, the Bahamas, the Dominican Republic, Saint Vincent and the Grenadines and Suriname. Concern about emerging Ecstasy use was raised at a recent meeting of the Caribbean Regional Drug Information Network.[17] In a 2000 survey conducted in the Cayman Islands, Ecstasy

lifetime prevalence was reported as 2.6 per cent.[18] Problematic levels of amphetamine use had also been reported by a 2000 school survey in the metropolitan area of Port-au-Prince: almost 12 per cent (11.7 per cent) reported amphetamine use in the last month, while last month prevalence rates for marijuana and cocaine were much lower.[7]

26. Increased ATS abuse was reported in Cameroon, Namibia, South Africa and Zimbabwe. Nigeria reported a stable situation. Again, overall reporting on ATS abuse trends in Africa is difficult because of the lack of reliable data. However, the abuse of ATS drugs does not appear to be a pronounced problem in southern and eastern Africa, while there is concern in other areas of Africa where the situation is less clear.

## C. Cocaine

27. Cocaine remains the primary drug of concern across the Americas and the Caribbean regions. However, cocaine abuse is not restricted to those regions and there are reports of it occurring elsewhere. However, in terms of the number of individuals affected, the Americas remain the region in which cocaine problems are most pronounced. As with other drugs, the mode of administration is important in understanding abuse patterns. Cocaine can be relatively easily converted between its salt and base forms. This allows snorting/sniffing, injection and smoking all to be common modes of administration. Of those methods, cocaine injection is usually the least commonly found behaviour. Smoking cocaine products, such as crack cocaine, is particularly associated with severe problems. Dependent and chronic patterns of abuse are common with this mode of administration and a strong association has been observed between crack cocaine smoking and socially negative behaviours, such as criminal offending. Some evidence exists that links smoking cocaine to elevated risks of HIV infection, either through an increased incidence of high-risk sexual encounters or through involvement in sex for money—or sex for drug—exchanges. This is a particular concern in many countries of Latin America and the Caribbean where drug injection is not common. Twenty-five countries provided data on cocaine trends in their responses to the annual reports questionnaire, of which 15 reported an increase in abuse, 7 a stable situation and 3 a decrease in levels of abuse.

28. Reports from Latin America suggested stable to increasing cocaine abuse, with increases noted in Chile, Colombia, El Salvador, Mexico and Peru. Argentina, Costa Rica and Panama reported stable levels of abuse and the Bahamas was the only country to report a decrease in cocaine abuse.

29. Cocaine and crack cocaine use continued to decline in most areas of the United States and that downward trend was especially striking in areas where abuse of the drugs had been highly concentrated in the past, such as the north-east, mid-Atlantic and northern mid-west regions. The population of crack cocaine users appeared to be ageing, although the overall level of use remained high, as did morbidity and mortality associated with the drug, with cocaine being responsible for the most drug-related deaths in nine CEWG sites. Cocaine was frequently used either concurrently or sequentially with other substances.[4] Cocaine use (including crack cocaine) among school students also decreased from 1999 to 2000, although use among children in the 8th to 10th grades increased slightly in the 1990s, the lifetime prevalence of cocaine use being 6.9 per cent among 10th grade students in the latest 2000 survey.[5] Survey data from Ontario, Canada, also showed a decline in the use of cocaine from the mid-1980s to 1998; however, there was a subsequent rise in use with lifetime prevalence rising from 4.6 per cent in 1998 to 6.4 per cent in 2000.[6]

30. Within the Caribbean, cocaine abuse is widely reported. All 15 countries participating in the Caribbean Drug Information Network reported cocaine abuse in their countries.[19] School survey data indicated that lifetime use of cocaine among students ranged from 1.3 per cent to 1.7 per cent.[19, 20] A study of drug users in Barbados found that 6 per cent reported cocaine to be their primary drug of choice. Prevalence rates among populations at risk are likely to be considerably higher. The newly formed surveillance network for the region was taking up the topic and focused studies and school surveys were planned for the region in the coming year.

31. Several European countries reported an increase in cocaine abuse—Belarus, Hungary, Ireland, Portugal and Spain. The only other European countries reporting on cocaine—the Czech Republic, Liechtenstein and Switzerland—indicated stable levels

of abuse. While there was concern about rising levels of cocaine use, especially in some of the larger cites, the data remained mixed. In western Europe there were reports of an overall upward trend in prevalence of cocaine use through the 1990s, but the current trends remained unclear.[2] The European Monitoring Centre for Drugs and Drug Addiction reported that there were no clear signs yet of a general increase in cocaine use either among the general population or among school children in Europe.[16] The lifetime prevalence of young people aged 15 to 16 remained low, the average being 1 per cent. However, targeted surveys of users revealed the high level of recreational use of cocaine powder in certain social settings, in particular among groups called "dance-goers" or "clubbers". In addition, reports from some large metropolitan areas suggested pockets where cocaine use might be increasing.

32. While the lifetime prevalence of cocaine among young adults from the general population generally ranged from less than 1 per cent to 6.4 per cent, the targeted surveys in the same age group revealed rates among "clubbers" as high as 42 to 62 per cent.[3, 16] In the United Kingdom there is increasing evidence of high levels of cocaine use among young people in some urban areas. The 2000 British Crime Survey noted that over 11 per cent of those aged between 16 and 29 years living in London reported cocaine use in the last 12 months. However, figures for other areas were far lower. The study noted that there was a concern that young people might be switching from Ecstasy to cocaine use, possibly in response to media attention to the harms associated with Ecstasy.[21]

33. Three African countries reported an increase in cocaine abuse, Namibia, Nigeria and South Africa, while Zimbabwe reported stable levels of abuse. Of the four Asian countries and territories that reported on cocaine abuse, Hong Kong SAR, India and Lebanon indicated increased abuse, whereas Japan noted some decrease in abuse. In general, only sporadic reports of cocaine abuse appeared from the region and concerns about stimulant drugs focused primarily on methamphetamine. In Australia, cocaine was reported only to be readily available in Sydney, where its use had been apparent for several years. There had been reports of a recent increase in cocaine injection in Sydney in response to the decreased availability of heroin in 2001.[12]

## D. Cannabis

34. Overall, cannabis in one form or another remains the illicit drug most commonly abused globally. This is reflected in the annual reports questionnaire response rate for cannabis, which was higher than for other types of drug. Fifty-one countries responded to the trend question, with most (38 countries, or 75 per cent) of those responding indicating increased cannabis abuse. Nine countries reported stable levels of cannabis abuse (17 per cent of those responding) and only four countries (8 per cent) reported decreased abuse of the drug, all of them in Asia.

35. Although evidence suggests that cannabis is the most common illicit drug used in most countries, estimates for the extent of cannabis abuse are mostly restricted to developed countries. Despite this, the available information from developing regions suggests that cannabis abuse is widespread and may be increasing in many countries. Even though cannabis may not feature to the same extent as a drug associated with acute health problems, such as heroin, cocaine or ATS, the relatively greater extent of its abuse presents a challenge to many countries. Additionally, in some developing countries in which cannabis use is widespread there are worries about the association of cannabis abuse with acute mental health problems and psychiatric emergencies. The issue remains poorly understood and a better understanding of the impact that cannabis consumption has on the health systems of countries in Africa, the Caribbean and elsewhere is required. This is particularly true in Africa, where cannabis abuse accounts for a substantive proportion of psychiatric admissions in several countries[22] and reports suggest that cannabis abuse is increasing.[23] All of the five African countries that reported on cannabis trends through the annual reports questionnaire, Cameroon, Namibia, South Africa, Zambia and Zimbabwe, noted increased levels of abuse. While data on cannabis consumption in Africa remain scarce, evidence gathered during the development of drug information systems in southern[23] and eastern Africa, together with specialized survey research conducted in western Africa,[24] suggested that cannabis was the most common illicit drug used in the region. Survey data from selected countries in the region also show that cannabis abuse is predominantly a problem among young males.[25, 26] For example, a 1998 survey of substance abuse among students in Swaziland found

that 7.5 per cent of male students had taken cannabis in the last month, compared with only 1.4 per cent of female students.[25]

36. The most recent estimates provided on the extent of cannabis abuse in western Europe showed that between 10 and 25 per cent of the general population had taken the drug in their lifetime, with levels of consumption being highest among young adults. The highest levels of consumption were in the United Kingdom, where 25 per cent of the general population (16-59 years) and 42 per cent of young adults (16-29 years) had used the drug in their lifetime.[16] Higher rates of cannabis consumption can be seen in Australia, where 39 per cent of the general population, almost two thirds of those in their twenties and 45 per cent of those aged 14-19 had taken the drug in their lifetime.[27] In the United States, lifetime prevalence of cannabis use was 34.2 per cent among the general population and 46 per cent among young people of 18-25 in the year 2000.[28]

37. Cannabis is also the most common drug abused by adolescents, with estimates of lifetime prevalence among European school students ranging from 1 per cent to 35 per cent, with increasing consumption noted in most countries.[3] The comparable figure from the United States—41 per cent—is higher than in any of the EU member States, even if the trend in adolescents' lifetime cannabis use has remained rather steady during late 1990s.[5] Data from the 1999 school survey in Ontario, Canada, indicated that 34.7 per cent of school students had used cannabis at some time, while the 1999 national survey of school students in Australia showed similarly high levels of use, with nearly one third of school students (12-17 years) and nearly half (47 per cent) of those aged 16-17 years having used the drug at some time.[29]

38. In terms of trends in cannabis use, increasing consumption was noted across Europe, with 18 of the 22 countries responding noting an increase in cannabis abuse. The European Monitoring Centre for Drugs and Drug Addiction also reported a trend towards increasing prevalence of cannabis use during the 1990s, with that increase being proportionally greater in the countries where lifetime prevalence was low in the early 1990s.[16] Both Australia and New Zealand reported increased cannabis abuse.

39. There was some evidence from the CEWG that cannabis use was stabilizing in particular areas of the United States, following the previous upsurge in use seen between 1990 and 1998. Despite that stabilization of use, demand for treatment for the drug remained high.[4] Use of cannabis among school students had remained stable since 1999.[5]

40. In many other countries in the Americas cannabis abuse was reported to be increasing (Argentina, Bahamas, Chile, Colombia, Costa Rica, Mexico, Panama and Peru). This is consistent with the findings of the Inter-American Drug Abuse Control Commission (CICAD), which noted an increase in drug abuse in the region.[21] Canadian survey data from Ontario (2000) showed an increase in the number of young cannabis users, with over one quarter (28.2 per cent) of those aged 18-29 years having taken the drug in the last year, compared with 18.3 per cent in 1996.[6]

41. Cannabis use is also common in the Caribbean. School survey data from the region indicated that lifetime use of cannabis among students ranged from 8 per cent to 26.9 per cent.[19] A national school survey in Jamaica found that 27 per cent of students had used cannabis at some time, while 8 per cent had used it in the last month. A study in Barbados found that 75 per cent of drug users interviewed named marijuana as their primary drug of choice.[19] Problems associated with cannabis use were also evident in the overseas countries and territories based on reports from country representatives at a recent meeting on drug problems in the Caribbean.[19]

42. Increases in cannabis use were noted in only 5 of the 12 Asian countries reporting on cannabis use (Azerbaijan, Japan, Malaysia, Myanmar and Sri Lanka), while Brunei Darussalam, Indonesia and Uzbekistan reported stable levels of abuse. Decreased cannabis abuse was reported in India, Kyrgyzstan, the Philippines and Singapore.

## III. Drug injection and transmission of blood-borne viruses

43. An estimated 40 million people were living with HIV/AIDS infection at the end of 2001. Injecting drug use is among *the major forces driving the epidemic*, with a rapid increase in the number of IDUs in many countries in the 1990s. Injecting drug use now affects over 135 countries and it has been estimated that worldwide there may be nearly 3 million IDUs with

HIV infections result from injecting drug use, but in some European and Asian countries over 50 per cent of HIV infections are attributed to injecting drug use.[30] Injecting drug use is considered a significant mode of HIV transmission, in particular in some eastern European countries, in countries in the former Union of Soviet Socialist Republics and in countries in South-East Asia, the Pacific, Latin America, western Europe and North America.[31]

44. The global trend in HIV infection among injecting drug users has shown a steady increase over the last decade. HIV infection among IDUs was reported by 72 countries and territories in 1995 (E/CN.7/1997/3, para. 19) and 93 countries and territories in 1998 (E/CN.7/2000/4, para. 23). The latest United Nations Joint HIV/AIDS Programme (UNAIDS)/World Health Organization (WHO) figures for the global HIV/AIDS epidemic show that by mid-1999 a total of 114 countries and territories had reported HIV infection among IDUs, a stark increase from 52 countries in 1992.[32]

45. The countries in the former Union of Soviet Socialist Republics are still experiencing the one of the fastest growing rates of HIV/AIDS infection globally, with infection rates in many newly independent States estimated to be doubling each year. The total number of cases of HIV/AIDS in the Russian Federation is expected to rise by the year 2005 to more than 5 million. Injecting drug use is likely to be a significant factor in that increase.[33] In Asia, drug-related HIV epidemics are also spreading rapidly through injecting as that mode of administration becomes more prevalent. For example, at least half of IDUs in Nepal were estimated to be HIV-positive in the late 1990s, while in Jakarta, HIV prevalence among IDUs increased from 15 per cent in 1999 to 40 per cent in 2000.[34] Several provinces in China also reported local HIV prevalence among IDUs above 70 per cent. In western Europe there are large differences between countries with regard to HIV infection among IDUs, varying from about 1 per cent in the United Kingdom to 32 per cent in Spain. Although overall the level of new infections in the EU has stabilized or fallen during the late 1990s, possible concern has recently been expressed concerning increased infection rates in Austria, Finland, Ireland, Luxembourg, the Netherlands and Portugal.[16]

46. While the relationship between drug injection and HIV infection is well understood, this may not be the only association between drug abuse and elevated rates of HIV infection. Some evidence exists to suggest a link between some patterns of non-injecting drug abuse and HIV infection. It has been suggested in particular that chronic cocaine use may result in an increase in sexual behaviours that raise the risk of HIV infection. This area remains poorly understood and the attribution of causal relationships between behavioural variables is extremely difficult. Nonetheless, this remains an important area for further study, if HIV infection amongst drug-abusing populations is to be addressed comprehensively.

47. HIV is not the only blood-borne infection to be transmitted by drug injection. Both hepatitis C (HCV) and hepatitis B (HBV) infections are also highly prevalent among injecting drug users, as they are similarly transmitted through blood-to-blood contact during the sharing of contaminated injecting equipment. WHO estimates that about 170 million people, 3 per cent of the world's population, are infected with HCV. Areas of highest HCV prevalence can be found in Africa, the eastern Mediterranean, South-East Asia and the western Pacific.[35] In Europe, where injecting drug use accounts for the majority of new HCV infections, available data show that between 40 and 90 per cent of IDUs are infected with the virus. Of the people who have been infected with HBV, more than 350 million have chronic (lifelong) infections. In sub-Saharan Africa and most of Asia and the Pacific, the majority of people become infected with HBV during childhood and 8-10 per cent of the general population become chronically infected.[36] Data on HBV among IDUs in Europe indicate prevalence varying between 20 and 60 per cent.[16] In countries with significant injecting populations, the long-term costs associated with addressing health problems resulting from HCV infection are likely to be considerable. For those countries where HIV rates are low among injectors, HCV infection is likely to be a major cause of morbidity and mortality among that group in the longer term.

## IV. Data collection: an information base for action

48. A key recommendation of the Declaration on the Guiding Principles of Drug Demand Reduction (General Assembly resolution S-20/3, annex) is that States should engage in regular assessments of the drug abuse situation using similar methods and procedures. The information presented above illustrates both the considerable efforts made by Member States to understand patterns and trends in drug abuse and the challenges that are still present. UNDCP has been working to assist Member States to build an improved and more comprehensive picture of the drug abuse situation. The revised part II of the annual reports questionnaire includes core indicators that have been developed through a consensus-building process and reflect recognized good practice. It is hoped that the revised instrument will result in improved levels of reporting. To further support annual reports questionnaire submissions, UNDCP is preparing materials to assist Member States in assembling the data required and encouraging the designation of technical focal points, in line with General Assembly resolution 44/3. As part of that process, the Global Assessment Programme on Drug Abuse has been assisting countries to develop improved capacity to monitor drug abuse and encouraging the adoption of good methodological practice. Technical manuals on the building of information networks, school surveys and innovative methods of estimating prevalence are also being prepared. During 2001, the Global Assessment Programme supported the launch of two new drug epidemiological networks, in eastern Africa and the Caribbean.

49. Critical to improving the standardization of data and the dissemination of good practice is establishing partnerships at the national, regional and global levels. UNDCP has worked closely with regional organizations such as the European Monitoring Centre on Drugs and Drug Addiction and the Organization of American States to ensure a complementary approach to data collection. As part of that process a technical meeting on drug epidemiology was held in Vienna from 3 to 5 December 2001. The meeting was a follow-up to that held in Lisbon in January 2000, where the technical requirements for drug information systems were discussed. The issues that emerged from the recent Vienna technical meeting included the need to move forward in sharing good practice on methodological developments and the further harmonization of approaches, the importance of early warning data on emerging trends, the need for ethical guidelines and new approaches for estimation of prevalence. One clear conclusion of the participants was that, although considerable efforts were still required, much progress had been made in improving understanding of patterns and trends in drug consumption. Furthermore, compared with the situation a few years ago, there had been a dramatic move towards adopting similar approaches and procedures. That improvement had not been achieved by simply adopting solutions that had been applied elsewhere, but rather through a developmental process that recognized the need to configure data collection approaches to suit national circumstances, while appreciating the benefits of adopting harmonized measures and proven good practice.

## V. Human immunodeficiency virus (HIV) infection among drug abusers: a key issue for the development of improved demand reduction responses

50. As described above, strong evidence points to a growing spread of HIV/AIDS associated with drug abuse in several parts of the world. UNDCP has accordingly scaled up its programme activities in that area. Its work has been guided by three policy documents. Firstly, the Declaration on the Guiding Principles of Drug Demand Reduction states that activities should cover all areas of demand reduction, from discouraging initial use to reducing the negative health and social consequences of drug abuse for the individual and society as a whole. It is recognized that HIV/AIDS constitutes one of the most serious potential harms of drug abuse. Secondly, the Administrative Committee on Coordination (ACC) Subcommittee on Drug Control, at its eighth session, held in Vienna on 28 and 29 September 2000, endorsed the draft position paper of the United Nations system on preventing the transmission of HIV among drug abusers (ACC/2000/17, para. 3 and annex IV), which called for a comprehensive package of prevention and care among IDUs to include HIV/AIDS information and education, voluntary and confidential HIV testing and

counselling, a variety of treatment options, including oral substitution therapy, access to clean needles and syringes, general survival services and primary health care, as well as referral for specialized care, as appropriate. Thirdly, the Declaration of Commitment on HIV/AIDS sets out targets for Member States on HIV prevention and care in general and specifically among groups with high or increasing rates of HIV infection, including IDUs.

51. The UNDCP activities in the field of HIV/AIDS are diverse. Most involve the mainstreaming of HIV/AIDS elements into the Programme's demand reduction work. Other activities include support for the provision and easy access to treatment and rehabilitation. In line with the position paper of the United Nations system (ACC/2000/17, annex IV), the organization supports the provision of diversification of services to IDUs, to prevent the spread of HIV among IDUs and from them to their non-injecting sexual partners and the general population. Further, the Programme provides technical support in the areas of policy and legislation development, training and capacity enhancement and strategy development, as well as identification and dissemination of best practices.

52. Funding remains a major constraint to work on HIV/AIDS. The UNAIDS unified budget and workplan provides some core funds, but this remains largely inadequate. The poor funding situation has resulted in very limited coverage of UNDCP activities in areas of central and eastern Europe, the newly independent States and East Asia where the problem of injecting drug use is the greatest. Another major challenge is the need to establish the linkage between HIV and drug abuse in parts of the world where injection is not common. Further, UNDCP needs to play a major role, through active inter-agency collaboration, in the ongoing discourse and activities aimed at identifying best practice in prevention and care of HIV/AIDS associated with drug abuse.

53. As with other areas of demand reduction, it is also important to improve collection of data concerning drug injection and behaviours incurring a high risk of HIV infection. UNDCP has been in discussion with WHO and UNAIDS on how to improve estimation techniques in this area and measures of such behaviours. That work is continuing through a number of joint initiatives that will be reported on during 2002.

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# Annex

## Trends in drug abuse and country reporting

Table 1
**Trends in the abuse of heroin**[a]

| *Trends* | *Reporting in 2000, by region*[b] *and country/territory* |
|---|---|
| *Increase in abuse* | |
| Total number of countries reporting: 27 | Africa (4): Cameroon, Namibia, South Africa and Zambia |
| Percentage of 2000 reports: 60 | Americas (4): Canada, Colombia, Mexico and Panama |
| | Asia (6): Azerbaijan, India, Jordan, Kyrgyzstan, Sri Lanka and Uzbekistan |
| | Europe (12): Belarus, Czech Republic, Estonia, Finland, Greece, Hungary, Latvia, Lithuania, Poland, Romania, Sweden and Turkey |
| | Oceania (1): Australia |
| *Stable level of abuse* | |
| Number of countries reporting: 9 | Africa (1): Zimbabwe |
| Percentage of 2000 reports: 20 | Americas (2): Chile and United States of America |
| | Asia (1): Brunei Darussalam |
| | Europe (5): Denmark, Ireland, Liechtenstein, Netherlands and Switzerland |
| *Decrease in abuse* | |
| Number of countries reporting: 9 | Africa (1): Nigeria |
| Percentage of 2000 reports: 20 | Asia (6): Hong Kong Special Administrative Region of China, Indonesia, Japan, Malaysia, Myanmar and Singapore |
| | Europe (2): Portugal and Spain |

[a] Number of countries reporting: 45.

[b] Number of countries reporting indicated in parentheses.

Table 2
**Trends in the abuse of methamphetamine**[a]

| *Trends* | *Reporting in 2000, by region*[b] *and country/territory* |
|---|---|
| *Increase in abuse* | |
| Number of countries reporting: 17 | Africa (2): Namibia, South Africa |
| Percentage of 2000 reports: 85 | Americas (5): Argentina, Canada, Colombia, Mexico and Peru |
| | Asia (5): Brunei Darussalam, Japan, Malaysia, Philippines and Singapore |
| | Europe (5): Belarus, Estonia, Finland, Ireland and Switzerland |
| *Stable level of abuse* | |
| Number of countries reporting: 1 | Europe (1): Portugal |
| Percentage of 2000 reports: 5 | |
| *Decrease in abuse* | |
| Number of countries reporting: 2 | Europe (2): Czech Republic and Hungary |
| Percentage of 2000 reports: 10 | |

[a]Number of countries reporting: 20
[b]Number of countries reporting indicated in parentheses.

Table 3
**Trends in the abuse of amphetamine**[a]

| *Trends* | *Reporting in 2000, by region*[b] *and country/territory* |
|---|---|
| *Increase in abuse* | |
| Number of countries reporting: 11 | Africa (3): Nigeria, South Africa and Zimbabwe |
| Percentage of 2000 reports: 58 | Americas (2): Chile and Colombia |
| | Asia (2): Hong Kong Special Administrative Region of China and India |
| | Europe (4): Belarus, Estonia, Finland and Sweden |
| *Stable level of abuse* | |
| Number of countries reporting: 6 | Africa (1): Namibia |
| Percentage of 2000 reports: 32 | Americas (3): Argentina, Canada and El Salvador |
| | Europe (2): Liechtenstein and Switzerland |
| *Decrease in abuse* | |
| Number of countries reporting: 2 | Europe (2): Czech Republic and Hungary |
| Percentage of 2000 reports: 11 | |

[a]Number of countries reporting: 19.
[b]Number of countries reporting indicated in parentheses.

Table 4
**Trends in the abuse of amphetamine-type stimulants**[a]

| *Trends* | *Reporting in 2000, by region*[b] *and country/territory* |
|---|---|
| *Increase in abuse* | |
| Number of countries reporting: 19 | Africa (3): Cameroon, Namibia and South Africa |
| Percentage of 2000 reports: 66 | Americas (2): Canada and Mexico |
| | Asia (4): Hong Kong Special Administrative Region of China, Indonesia, Macao Special Administrative Region of China and Myanmar |
| | Europe (8): Belarus, Denmark, Estonia, Finland, Iceland, Lithuania, Poland and Republic of Moldova |
| | Oceania (2): Australia and New Zealand |
| *Stable level of abuse* | |
| Number of countries reporting: 8 | Americas (2): Argentina and United States of America |
| Percentage of 2000 reports: 28 | Europe (6): Czech Republic, Germany, Greece, Latvia, Netherlands and Spain |
| *Decrease in abuse* | |
| Number of countries reporting: 2 | Asia (1): Philippines |
| Percentage of 2000 reports: 7 | Europe (1): Hungary |

[a]Number of countries reporting: 29.

[b]Number of countries reporting indicated in parentheses.

Table 5
**Trends in the abuse of cocaine**[a]

| *Trends* | *Reporting in 2000, by region*[b] *and country/territory* |
|---|---|
| *Increase in abuse* | |
| Number of countries reporting: 15 | Africa (3): Namibia, Nigeria and South Africa |
| Percentage of 2000 reports: 60 | Americas (5): Chile, Colombia, El Salvador, Mexico and Peru |
| | Asia (2): Hong Kong Special Administrative Region of China and India |
| | Europe (5): Belarus, Hungary, Ireland, Portugal and Spain |
| *Stable level of abuse* | |
| Number of countries reporting: 7 | Africa (1): Zimbabwe |
| Percentage of 2000 reports: 28 | Americas (3): Argentina, Costa Rica and Panama |
| | Europe (3): Czech Republic, Liechtenstein and Switzerland |
| *Decrease in abuse* | |
| Number of countries reporting: 3 | Americas (1): Bahamas |
| Percentage of 2000 reports: 12 | Asia (2): Japan and Lebanon |

[a]Number of countries reporting: 25.

[b]Number of countries reporting indicated in parentheses.

Table 6
**Trends in the abuse of cannabis**[a]

| *Trends* | *Reporting in 2000, by region*[b] *and country/territory* |
|---|---|
| *Increase in abuse* | |
| Number of countries reporting: 38 | Africa (5): Cameroon, Namibia, South Africa, Zambia and Zimbabwe |
| Percentage of 2000 reports: 75 | Americas (8): Argentina, Bahamas, Chile, Colombia, Costa Rica, Mexico, Panama and Peru |
| | Asia (5): Azerbaijan, Japan, Malaysia, Myanmar and Sri Lanka |
| | Europe (18): Belarus, Czech Republic, Denmark, Estonia, Finland, Germany, Hungary, Iceland, Ireland, Latvia, Liechtenstein, Lithuania, Poland, Portugal, Republic of Moldova, Romania, Switzerland and Turkey |
| | Oceania (2): Australia and New Zealand |
| *Stable level of abuse* | |
| Number of countries reporting: 9 | Americas (2): El Salvador and United States of America |
| Percentage of 2000 reports: 17 | Asia (3): Brunei Darussalam, Indonesia and Uzbekistan |
| | Europe (4): Greece, Netherlands, Spain and Sweden |
| *Decrease in abuse* | |
| Number of countries reporting: 4 | Asia (4): India, Kyrgyzstan, Philippines and Singapore |
| Percentage of 2000 reports: 8 | |

[a]Number of countries reporting: 51.

[b]Number of countries reporting indicated in parentheses.